Welcome To Clarity Eye Care
Thank you for choosing our office for your vision care needs.

GENERAL INFORMATION Date_____

First Name_____ MI_____ Last Name_____

Age_____ Birthdate_____ Marital Status_____ Male / Female SS#_____

Address_____ City_____ State_____ Zip_____

Primary Phone_____Hm Wk Cell Alternate_____Hm Wk Cell

I am able to receive texting on my cell. YES NO

Preferred Language_____

E-Mail address_____

Race:
__ American Indian or Alaskan Native ___ Asian
__Black or African American ___ Hispanic
__ Native Hawaiian/Pacific Islander ___ White
Ethnicity:
__Hispanic or Latin __ Non-Hispanic or Latino
__Hawaiian/Pacific Native Islander

Employer/School_____ Occupation/School Grade_____

If a minor, name of parent or guardian_____

Emergency Contact_____ Relation_____ Phone_____

Who may we thank for referring you? _____

Do you wear glasses? Yes / No / All the time / Sometimes / Work only / Reading only / Driving only

How old are your present glasses?_____ Do you wear Sunglasses?_____

Do you use a computer/ tablet? Yes_____ No_____ How many hours a day?_____

Do you wear contacts? Yes_____ No_____ Would Like To Try Contacts_____

If Yes, What Type/Brand of Contact_____ Solution_____

Wearing schedule: **Daily / Overnight** Replacement Schedule: **Daily / 2 Week / Monthly / Yearly**

Date of Last Medical Exam_____/_____/_____ Primary Physician/Clinic_____

Date of Last Visual Exam_____/_____/_____ Primary Physician/Clinic_____

Have you ever had/used:	Yes	No	Explanation
Eye Injuries:	_____	_____	_____
Eye Surgeries:	_____	_____	_____
Eye Medication:	_____	_____	_____
Are you currently Pregnant/Nursing	_____	_____	_____

Have you ever been diagnosed with:	Yes	No	When were you diagnosed?
Cataracts:	_____	_____	_____
Glaucoma:	_____	_____	_____
Macular Degeneration	_____	_____	_____

What are your visual symptoms (with your current glasses or contacts if applicable): Please mark all that apply: Please indicate Right, Left or Both, along with severity 1(Low) 2(Moderate) 3(High)

RLB_____Blurred Vision/Distance	RLB_____Loss of Vision	RLB_____Dry Eyes	_____Migraine
RLB_____Blurred Vision/Near	RLB_____Crossed Eyes	RLB_____Red Eyes	Headaches
RLB_____Eye Pain/Soreness	RLB_____Wandering Eye	RLB_____Watery Eyes	
RLB_____Sandy/Gritty Feeling	RLB_____Floaters or Spots	RLB_____Itchy Eyes	_____Headaches
RLB_____Poor Night Vision	RLB_____Mucus Discharge	RLB_____Tired Eyes	
RLB_____Poor Color Vision	RLB_____Eye Infections	RLB_____Burning Eyes	
RLB_____Light Sensitivity	RLB_____Double Vision	RLB_____Eye Strain	
RLB_____See Halos Around Lights	RLB_____See Flashes of Light	RLB_____Droopy Lid	

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: ____**None** ____High Blood Pressure ____Stroke ____Heart Disease ____Vascular Disease ____High Cholesterol ____Other:	**Endocrine:** ____**None** ____Non-Insulin Dependent Diabetes ____Insulin Dependent Diabetes ____Thyroid Problem ____Hormonal Dysfunction ____Other:	**Respiratory** ____**None** ____Asthma ____Bronchitis ____Emphysema ____COPD ____Other:
Constitutional: ____**None** ____Cancer ____Trauma/Large Volume Blood Loss ____Developmental Disability ____Other:	**Ocular** ____**None** ____Glaucoma ____Macular Degeneration ____Detached Retina ____Other:	**Psychiatric:** ____**None** ____ADHD ____Depression ____Schizophrenia ____Other:
Neurological: ____**None** ____Multiple Sclerosis ____Epilepsy ____Cerebral Palsy ____Tumor ____Other:	**Musculoskeletal:** ____**None** ____Osteoarthritis ____Fibromyalgia ____Muscular Dystrophy ____Ankylosing Spondylitis ____Other:	**Immunologic:** ____**None** ____AIDS or HIV ____Rheumatoid Arthritis ____Lupus ____Neurofibromatosis ____Other:
Hematological: ____**None** ____Anemia ____Leukemia ____Other:	**Gastrointestinal:** ____**None** ____Crohn's ____Colitis ____Other:	**Ear/Nose/Throat:** ____**None** ____Hearing Loss ____Upper Respiratory Infection ____Other:
Dermatologic: ____**None** ____Eczema ____Rosacea ____Psoriasis ____Other:	**Allergies (please list)** ____**None** Drug: Environmental:	**Alcohol Use:** **Y** **N** Amount: **Tobacco Use:** **Y** **N** Amount:

Please list physical reactions to above allergies:_____

Please list any medications and/or drugs that you are taking (including herbal): **See Attatched List:**____

1_____For_____ 6_____For_____
2_____For_____ 7_____For_____
3_____For_____ 8_____For_____
4_____For_____ 9_____For_____
5_____For_____ 10_____For_____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE/CONDITION

Retinal Detachment: Yes/No _____ Blindness: Yes/No _____
High Blood Pressure: Yes/No _____ Cataracts: Yes/No _____
Diabetes: Yes/No _____ Glaucoma: Yes/No _____
Cancer: Yes/No _____ Crossed Eyes: Yes/No _____
Heart Disease: Yes/No _____ Macular Degeneration: Yes/No _____
Thyroid Disease: Yes/No _____ Lupus: Yes/No _____

Patient Signature_____

Reviewed by Doctor:_____ **Date**_____

Office Use Only Reviewed by:

_____ **Date**_____ **Dr. Initial**_____

_____ **Date**_____ **Dr. Initial**_____

Clarity Eye Care
Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient_____**DOB**_____

Name of Insured_____**DOB**_____

Relationship to patient_____ SS# of insured_____

Address if different_____ Phone_____

Employer of insured_____ Occupation_____

Name of Vision Insurance_____

ID#_____ **Group/Policy #**_____

Name of Medical Insurance_____

ID#_____ **Group/Policy #**_____

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my dependent to:_____

_____ _____
Signature of patient or parent if minor Date

HIPAA PRIVACY PRACTICE ACKNOWLEDGEMENT

I am aware of Clarity Eye Care's Notice of Privacy Practices.

_____I would like a copy. _____I do not want a copy.

Signature: _____ **Date:** _____